Kansas Medical Assistance Programs

HEALTHCONNECT Kansas

From the office of the Fiscal Agent

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

Weight Loss Initial Request Form

Orlistat (Xenical ®), Sibutramine (Meridia ®) or Phentermine ®

Consumer Name: _____
Consumer Medicaid ID #: _____ **Date Of Birth:** ____/____/_____
****Name of medication requested and instructions:**
_____

The following are **required** measurements and must be no more than 14 days old:
Weight:_____ **Waist:** _____
Height: _____ **BMI:** _____**Date measurements were obtained:** ____/____/_____

Please indicate if the consumer has any of the following risk factors:

- Hypertension: _____ - Dyslipidemia: _____
- Coronary Artery Disease: _____ - Diabetes: _____ (Please indicate type: _____)
- Sleep Apnea: _____ - Documented arthritis of weight beating joints: _____
- Others: _____

Is there a treatment plan and goal of therapy in the medical record, which includes a nutritionally balanced reduced calorie diet, exercise and behavioral counseling? _____
Has a daily multivitamin been prescribed and/or recommended? _____
Is the consumer pregnant or breast-feeding? _____
If requesting orlistat (Xenical ®) please answer the following:

- Does the consumer have evidence of cholestasis? _____
- Does the consumer have evidence of chronic intestinal malabsorption? _____

If requesting sibutramine (Meridia ®) please answer the following:

- Is the consumer taking a MAOI (Nardil, Parnate, etc)? _____ Name of drug: _____
- Does the consumer have uncontrolled hypertension? _____
- Does the consumer have unstable cardiovascular disease? _____
- Does the consumer have a significant cardiac arrythmia? _____

(***For renewal of Xenical ® or Meridia ® the consumer must lose 5% of the baseline weight supplied after initial 3 month authorization.)***

If requesting Phentermine ® please answer the following:

- Is the consumer taking a MAOI (Nardil, Parnate, etc) within the last 14 days? _____
  Name of drug: _____
- Does the consumer have uncontrolled hypertension? _____
- Does the consumer have unstable cardiovascular disease? _____
- Does the consumer have a significant cardiac arrythmia? _____

Physician's Printed Name: _____**Provider Medicaid ID #:** _____
Signature of Physician or Designee: _____ **Date:** ____/____/_____
Phone number: (____)_____ **Fax number:** (____)_____

Pharmacy Name: _____ **Provider Medicaid ID#:** _____
NDC Requesting: _____
Phone number: (____)_____ **Fax number:** (____)_____

Completed form should be faxed to 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.
If a case has been started and the information requested is not received within 15 working days, the case will be denied.

Revised 3/2006